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10098

10073

10098

CERTIFICATE OF DEATH

Reg. Dist. No.

1

VS A15 (4)  
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville, Md.</b> c. LENGTH OF STAY IN 1b <b>5yr.1mo.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b> d. STREET ADDRESS <b>08X-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Benjamin</b> Last <b>Abell</b>		4. DATE OF DEATH Month <b>9</b> Day <b>4</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-23-72</b>
9. AGE (In years last birthday) <b>86</b>		10. IF UNDER 1 YEAR Months <b>8</b>	11. IF UNDER 24 HRS. Days <b>4</b> Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician, retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Abell</b>		14. MOTHER'S MAIDEN NAME <b>Mandy Dorsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b> <b>more than 5 yrs.</b> <b>more than 10 years.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>CBS asso. with disturbance of metabolism, growth or nutrition with senile brain disease, with psychotic reaction, plus pulmonary TBC.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August</b> 19 <b>55</b> , to <b>9-4</b> 19 <b>59</b> , that I last saw the deceased alive on <b>9-4-59</b> , 19 <b>59</b> , and that death occurred at <b>5:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>9-4-59</b>			
ACTUAL SIGNATURE <b>Walter Knopp</b> PHYSICIAN'S NAME (Type) <b>Walter Knopp, M.D.</b>		M.D. <b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady's Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Medley's Neck, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>	
ADDRESS <b>Leonardtown, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Lane</b>	

CERTIFICATE OF DEATH

1900

<p>NAME OF DECEASED <i>John A. Smith</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>		<p>DATE OF BIRTH <i>Jan 15 1855</i></p>	
<p>PLACE OF BIRTH <i>Maryland</i></p>		<p>RESIDENCE <i>Baltimore</i></p>		<p>DATE OF DEATH <i>Dec 10 1900</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>		<p>INTERMEDIATE CAUSE <i>Coronary Artery Disease</i></p>		<p>FINAL CAUSE <i>Atherosclerosis</i></p>	
<p>PLACE OF DEATH <i>Home</i></p>		<p>DATE OF INTERMENT <i>Dec 12 1900</i></p>		<p>PLACE OF INTERMENT <i>St. Mary's Cemetery</i></p>		<p>NAME OF INTERMENT SOCIETY <i>St. Mary's</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>John A. Smith</i></p>		<p>SIGNATURE OF REGISTRAR <i>John A. Smith</i></p>		<p>SIGNATURE OF CLERK <i>John A. Smith</i></p>		<p>SIGNATURE OF JURY <i>John A. Smith</i></p>	

10099

## CERTIFICATE OF DEATH

10074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>35yrs.9mos.15days</b> <b>Baltimore</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>None - Came here from Bay View</b>		
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle Last <b>Adshead</b>			4. DATE OF DEATH Month <b>September</b> Day <b>7</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1882</b>		9. AGE (In years last birthday) <b>77</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Milker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b> ✓
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	INFORMANT Address <b>Springfield Hospital Records</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic nephritis</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, paranoid type.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Years:</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield State Hospital</b>	
20f. (City or town) <b>Baltimore</b>		(County) <b>Md.</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>September 7, 1959</b> , that I last saw the deceased alive on <b>September 7, 1959</b> , and that death occurred at <b>9:00A</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Agustin del Campo</b>		M.D. <b>Agustin del Campo, M.D.</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		SYKESVILLE, MARYLAND		DATE SIGNED <b>9/7/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>9.9.59</b>		22b. DATE THEREOF <b>9.9.59</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>U. of Md. Med. School</b>	
22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State) <b>Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Agustin del Campo</b>	
24a. REC'D BY REGISTRAR <b>SEP 11 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Agustin del Campo</b>		DATE <b>SEP 11 1959</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

• *Future research*

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1990

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10093

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10075

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster -- Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glover Nursing Home</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>A.</b> Last <b>BARNES</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>10,</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-10-1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saw Mill Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George W. Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Martha Bowers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Edgar R. Barnes, Marbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary insufficiency</b> DUE TO <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>6 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March, 1952</b> to <b>Sept. 10, 1959</b> , that I last saw the deceased alive on <b>Sept 9, 1959</b> , and that death occurred at <b>7:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9 Reeselobane M.D. 15 Kemper Ave. 9/10/59</b> ACTUAL SIGNATURE <b>E Reese Wilkens Westminster Md</b> PHYSICIAN'S NAME (Type) <b>E Reese Wilkens Westminster Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-12-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sams Creek Brethren</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH 1900		PLACE OF DEATH DETROIT	
FULL NAME OF DECEASED JOHN J. WILSON		AGE 35	
SEX MALE		RACE WHITE	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
OCCUPATION CLOCK MAKER		RELIGION METHODIST	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF BURIAL JAN 10 1900		PLACE OF BURIAL CATHOLIC CEMETERY	
SIGNATURE OF REGISTRAR J. J. WILSON		SIGNATURE OF DECEASED JOHN J. WILSON	
DATE OF REGISTRATION JAN 10 1900		PLACE OF REGISTRATION DETROIT	
NAME OF REGISTRAR J. J. WILSON		NAME OF DECEASED JOHN J. WILSON	
DATE OF DEATH JAN 10 1900		PLACE OF DEATH DETROIT	
FULL NAME OF DECEASED JOHN J. WILSON		AGE 35	
SEX MALE		RACE WHITE	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
OCCUPATION CLOCK MAKER		RELIGION METHODIST	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF BURIAL JAN 10 1900		PLACE OF BURIAL CATHOLIC CEMETERY	
SIGNATURE OF REGISTRAR J. J. WILSON		SIGNATURE OF DECEASED JOHN J. WILSON	
DATE OF REGISTRATION JAN 10 1900		PLACE OF REGISTRATION DETROIT	
NAME OF REGISTRAR J. J. WILSON		NAME OF DECEASED JOHN J. WILSON	

1

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
JAN 10 1900  
DETROIT  
JOHN J. WILSON  
CLOCK MAKER  
HEART DISEASE  
NATURAL  
CATHOLIC CEMETERY  
J. J. WILSON  
JAN 10 1900  
DETROIT  
J. J. WILSON  
JOHN J. WILSON



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10100

## CERTIFICATE OF DEATH

Reg. Dist. No.

10076

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Finksburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Finksburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>Route #1 Box 497</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>BOHR</u> Last <u>BOHR</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 17, 1886</u>	
9. AGE (In years last birthday) yrs. <u>72</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired B&amp;O</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Quantico, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Bohr</u>				14. MOTHER'S MAIDEN NAME <u>Mary Groff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>705-12-3526</u>			
17. INFORMANT <u>Mrs. Doris C. Bohr, Rt #1, Box 497</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma - metastatic</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma sigmoid</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>44 yr +</u> <u>34 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>56</u> , to <u>Sept 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 15</u> , 19 <u>59</u> , and that death occurred at <u>9</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>9/16/59</u> ACTUAL SIGNATURE <u>James J. Marsh</u> M.D. <u>  </u> PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u> <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 19, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Winfield, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Newell - P. Newell</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10077

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10101

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO. MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER.</u>		c. LENGTH OF STAY IN lb <u>27 MRS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AT HOME</u>		d. STREET ADDRESS <u>OLD BALTIMORE ROAD -</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>CHARLES</u> Middle <u>BOWSTEAD</u> Last		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>23</u> Year <u>19 '59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POULTRY &amp; ZEPH PHOTO. STUDIO.</u>	
11. BIRTHPLACE (State or foreign country) <u>DENVER, COL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM BOWSTEAD.</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN STICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-367258</u>	
17. INFORMANT <u>WIFE - Mrs. Wm. Charles BOWSTEAD (HOME)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> (c) <u></u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Walter Speicher</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Acting</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>26th/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LODDEN PARK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Saffell - Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 24 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Frank</u>	



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-101

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DETAILED STATEMENT OF CAUSE OF DEATH

DETAILED STATEMENT OF MANNER OF DEATH

DETAILED STATEMENT OF OTHER FACTS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10102

## CERTIFICATE OF DEATH

Reg. Dist. No.

10078

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Myersville</b>	
c. LENGTH OF STAY IN 1b <b>3 m 20 d</b>		d. STREET ADDRESS <b>10X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Addie</b> Middle <b>Harris</b> Last <b>Browning</b>		4. DATE OF DEATH Month <b>September</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1871</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown Harris</b>		14. MOTHER'S MAIDEN NAME <b>unknown -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Springfield State Hospital Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal bronchopneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH Hours <b>422.1</b> Years <b>422.1</b> Years <b>422.1</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 9, 1959</b> , to <b>Sept. 17, 1959</b> , that I last saw the deceased alive on <b>Sept. 17, 1959</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oak Street</b> DATE SIGNED <b>9-17-59</b>			
ACTUAL SIGNATURE <b>Konstantin Weber</b>		M.D. <b>Oak Street</b>	
PHYSICIAN'S NAME (Type) <b>Konstantin Weber, M. D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>9-20-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Lutheran</b>	22d. LOCATION (City, town, or county) (State) <b>Myersville, Fred. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Biele</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton A. Kline</b>			

CERTIFICATE OF DEATH

10105

Reg. Dist. No.

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CITY [Illegible]	
COUNTY [Illegible]		STATE [Illegible]		ZIP CODE [Illegible]		MEDICAL EXAMINER [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF CLERK [Illegible]		SIGNATURE OF JURY [Illegible]		SIGNATURE OF JUDGE [Illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10103

CERTIFICATE OF DEATH

10079

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>				c. LENGTH OF STAY IN 1b <b>15 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R.D.1 (Silver Run)</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mervin E. Cashman</b>				4. DATE OF DEATH Month Day Year <b>9/25/59 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/28/1878</b>	9. AGE (In years last birthday) yrs. <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bldg. all kinds</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter N. Cashman</b>				14. MOTHER'S MAIDEN NAME <b>Laura Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-5913</b>		17. INFORMANT Address <b>Mrs. Mervin E. Cashman, Westminster, Md. R.D.1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-22</b> , 19 <b>59</b> , to <b>9-25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9-24</b> , 19 <b>59</b> , and that death occurred at <b>4:10 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. L. Potter</b>				ADDRESS (Street, city or town, state) <b>12 W. KING ST. Littlestown, Pa.</b>		DATE SIGNED <b>9-25-59</b>	
PHYSICIAN'S NAME (Type) <b>L. L. POTTER M.D.</b>				<b>12 W. KING ST. LITTLESTOWN, PA</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church Of God Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Uniontown, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>				ADDRESS <b>Littlestown, Pa.</b>		24a. REC'D BY REGISTRAR <b>DATE SEP 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>			







**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 10080

10104

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>28 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Constance</b> Middle <b>H.</b> Last <b>Coffin</b>				4. DATE OF DEATH Month <b>9</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/18/77</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>9</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles E. Coffin</b>				14. MOTHER'S MAIDEN NAME <b>Catherine R. Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>John C. Belfield 1329 Wynngate Rd. Penna.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>401.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute pericarditis</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, hephrenic type. Fracture, intertrochanteric, left femur.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <b>5:10</b> <b>9/16/</b> <b>19 59</b> Hour <b>3:00</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Sykesville</b>		(County) <b>Carroll</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James T. Marsh</i> EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>9/27/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Johns Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Beltville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 6 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kenna</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Place of Death _____		Age of Deceased _____	
Sex of Deceased _____		Race of Deceased _____	
Cause of Death _____		Manner of Death _____	
Signature of Medical Examiner _____		Signature of Coroner _____	
Date of Certificate _____		Office of Medical Examiner _____	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10081

Reg. Dist. No.

10105

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Carroll</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> <span style="float: right;">b. COUNTY <span style="font-size: 1.2em;">Carroll</span></span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">rural--New Windsor</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">5 yrs.</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">X rural--New Windsor</span>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <span style="font-size: 1.2em;">R.D. # 1</span>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="font-size: 1.2em;">ROBERT</span> Middle <span style="font-size: 1.2em;">S.</span> Last <span style="font-size: 1.2em;">COHEN</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">SEPT.</span> Day <span style="font-size: 1.2em;">22,</span> Year <span style="font-size: 1.2em;">19 59</span>					
5. SEX <span style="font-size: 1.2em;">male</span>		6. COLOR OR RACE <span style="font-size: 1.2em;">white</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">5-24-1910</span>			
9. AGE (In years last birthday) <span style="font-size: 1.2em;">49 yrs.</span>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Poultryman</span>			
10b. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">owner</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Moses S. Cohen</span>			
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Beatrice Rosenfeld</span>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <span style="font-size: 1.2em;">?</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">?</span>		17. INFORMANT Address <span style="font-size: 1.2em;">Mrs. Elvira J. Cohen, same</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">SM suffocation</span> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <span style="font-size: 1.5em;">Suffocated by Plastic bag over head</span>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <span style="font-size: 1.2em;">9/22</span> 19 <span style="font-size: 1.2em;">59</span> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">Home</span>		20f. (City or town) (County) (State) <span style="font-size: 1.2em;">New Windsor Carroll Md</span>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <span style="font-size: 1.2em;">James S. Marsh</span>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <span style="font-size: 1.2em;">JAMES T. MARSH</span>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <span style="font-size: 1.5em;">9/23/59</span>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Cremation</span>		22b. DATE THEREOF <span style="font-size: 1.2em;">9-28-1959</span>		22c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Loudon Park</span>		22d. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>			
23. FUNERAL DIRECTOR'S SIGNATURE <span style="font-size: 1.2em;">C. M. Waltz,</span>				ADDRESS <span style="font-size: 1.2em;">Winfield, Md.</span>		24a. REC'D BY REGISTRAR DATE <span style="font-size: 1.2em;">SEP 28 '59</span>			
24b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em;">Carlton S. K...</span>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10106 CERTIFICATE OF DEATH

10082

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>24yrs. 3mos. 20days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>122 Warren Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Effie May Moon</b> Middle <b>CONNORS</b> Last		4. DATE OF DEATH Month <b>September</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1872</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>King Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas O. Moon</b>		14. MOTHER'S MAIDEN NAME <b>Ellen A. Schaeffer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Psychosis with cerebral arteriosclerosis.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 11, 1958</b> to <b>September 11, 1959</b> , that I last saw the deceased alive on <b>September 11, 1959</b> , and that death occurred at <b>10:50A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank Magro M.D.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital 9/11/59</b>	
PHYSICIAN'S NAME (Type) <b>Frank Magro, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>9-15-59 U. of Md. Med. School</b>		22b. DATE THEREOF <b>Baltimore, Md.</b>	
22c. NAME OF CEMETERY OR CREMATOR <b>U. of Md. Med. School</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Thomas</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur H. Thomas</b>			

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10083

10107

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3615 Kimble Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Jay Davis</b>		4. DATE OF DEATH Month Day Year <b>September 3 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 12, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. AGE (In years last birthday) <b>77</b> yrs.	11. AGE (In years last birthday) <b>77</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metal worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ruben Davis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Slocum</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>193-01-9840</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac insufficiency</b> DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>Arteriosclerosis heart disease.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS due to arteriosclerosis.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 1, 1959</b> , to <b>September 3, 1959</b> that I last saw the deceased alive on <b>September 3, 1959</b> , and that death occurred at <b>1:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>9/3/59</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. J. J. McKee &amp; Sons - Balt.</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; H. ...</b>			

CERTIFICATE OF DEATH

10107

NEW YORK

BUREAU OF VITAL STATISTICS

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Place of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Signature of attending physician: \_\_\_\_\_

10. Signature of registrar: \_\_\_\_\_

11. Date of registration: \_\_\_\_\_

12. Registrar's office: \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10084**

**10108**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westminster</b> c. LENGTH OF STAY IN 1b <b>20 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R. 3 Sullivan Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westminster</b> d. STREET ADDRESS <b>R. 3 Sullivan Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD ROGER DELL</b> First Middle Last 4. DATE OF DEATH <b>Sept 23 1959</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>Dec. 25, 1895</b> 9. AGE (In years last birthday) <b>63</b> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b> 11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Thomas Dell</b> 14. MOTHER'S MAIDEN NAME <b>Mary E. Burns</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> 16. SOCIAL SECURITY NO. <b>217-07-4027</b> 17. INFORMANT <b>Mrs. Elsie P. Dell</b> Address <b>R. 3 Westminster, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGE - AXILLARY VESSELS</b> <b>9/2.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Caught in Corn Picker</b>	
20c. TIME OF INJURY Month, Day, Year <b>9 23 59</b> Hour <b>p.m.</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home farm</b> 20f. (City or town) <b>R3 Westminster</b> (County) <b>Carroll</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James J. Marsh</b> EXAMINER'S NAME (Type) <b>JAMES T MARSH</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>9/24/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-26-59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cemetery</b> 22d. LOCATION (City, town, or county) <b>Gamber Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b> ADDRESS <b>Westminster, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 28 '59</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



10-10-1918

10-10-1918

John R. Evans, Westchester, Maryland  
0-26-20  
MS. Edmund University, Oxford, England

DATE OF BIRTH  
PLACE OF BIRTH  
CITY OF BIRTH

1. I hereby certify that the above named person is a resident of the State of Maryland.  
2. I hereby certify that the above named person is a resident of the State of Maryland.

1. I hereby certify that the above named person is a resident of the State of Maryland.  
2. I hereby certify that the above named person is a resident of the State of Maryland.

217-07-4027-10, State R. J. Westchester, N.Y.  
Thomas J. Evans  
John R. Evans  
Dec. 27, 1895  
R. J. Evans  
Westchester, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10109

## CERTIFICATE OF DEATH

Reg. Dist. No.

10085

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>city</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>47 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		<b>3401-4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>1304 Aisquith St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>K.</b> Last <b>Fink</b>				4. DATE OF DEATH Month <b>9</b> Day <b>26</b> Year <b>1959</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>73 unknown</b>			
9. AGE (In years last birthday) <b>73?</b>		10. UNDER 1 YEAR Months <b>73?</b>		11. UNDER 24 HRS. Days <b>73?</b>		12. UNDER 24 HRS. Hours <b>73?</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>unk</b>					
17. INFORMANT <b>Springfield Hospital Records</b>				18. Aisquith St. <b>Mrs. Katherine A. - Moylan - Baltor., - Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Coronary occlusion</b> DUE TO (c) <b>Arteriosclerotic heart disease.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Hours</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, other and unspecified</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>March 7,</b> <b>1955</b> , to <b>Sept. 26,</b> <b>1959</b> , that I last saw the deceased alive on <b>September 26,</b> <b>1959</b> , and that death occurred at <b>2:00 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>9/27/59</b> ACTUAL SIGNATURE <b>Agustin del Campo.</b> M.D. <b>Springfield State Hospital</b> PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-29-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New-Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Luther H. Haight</b>				ADDRESS <b>Sykesville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>1 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>									

10022

CERTIFICATE OF DEATH

10109

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10086

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Taneytown</b>				d. STREET ADDRESS <b>Taneytown</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>O.</b> Last <b>FOGLE</b>				4. DATE OF DEATH Month <b>September</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 3, 1898</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Ann Fogle</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-40-1352</b>		17. INFORMANT Address <b>Mrs. Harry Fogle, Taneytown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed skull</b> <b>712.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b></b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell into mulcher (multure)</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>Abt. 12 noon 9/29 19 59</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>		M.D. <b>W. Bradley King, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>9/30/59</b>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) <b></b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 1, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rocky Hill Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Woodsboro, Maryland</b>	
23. FUNERAL DIRECTOR <b>C.O. Fuss &amp; Son</b>		ADDRESS <b>Taneytown, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Fuss</b>	

10028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10111

CERTIFICATE OF DEATH

Reg. Dist. No.

10087

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>115 Record Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Cordelia Davis Fox</b>		4. DATE OF DEATH Month Day Year <b>September 1, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 18, 1869</b>
9. AGE (In years last birthday) <b>89</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Franklin Davis</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Coblentz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. Subcapital fracture, neck of right femur.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 13, 1956</b> to <b>September 1, 1959</b> , that I last saw the deceased alive on <b>September 1, 1959</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustini del Campo</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		DATE SIGNED <b>9/2/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-4-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 4 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. E. &amp; K. &amp; S.</b>			

• **Explain** the importance of the following:

Latent class analysis (LCA) (McLerran, 1999)

[illegible]

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

*Submitted: 10 November 2009; Accepted: 17 February 2010*

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Journal of Interpersonal Violence 26(10)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**10112**  
**CERTIFICATE OF DEATH**

10088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>6 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>William</b> Last <b>Frush</b>				4. DATE OF DEATH Month <b>9</b> Day <b>5</b> Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/8/71</b>	
9. AGE (In years last birthday) <b>87 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miller in flour mill</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Frush</b>				14. MOTHER'S MAIDEN NAME <b>Mary Boger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-12-2068</b>			
17. INFORMANT <b>Frank Frush</b>				Address <b>Hampstead, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis Heart Disease</b> <b>420.0</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY DISEASE CONDITION, giving date (a) _____ <b>Chronic brain syndrome assoc. with disturbance of metabolism, growth or nutrition, senile brain disease with psychotic reaction Enlarged</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Prostate</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>8/9</b> , 19 <b>59</b> , to <b>9/5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9/5</b> , 19 <b>59</b> , and that death occurred at <b>4:30 A.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Agustin del Campo</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>9/5/59</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				<b>Sykesville Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadow Branch</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edw E. Tipton</b>				ADDRESS <b>Hampstead Md</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 9 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>			

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10113

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster Md.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural, Westminster, RD #7</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Westminster Md, RD #7</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>MAY</i> Middle <i>WILLIAM</i> Last <i>GEIMAN</i>				4. DATE OF DEATH Month <i>Sept.</i> Day <i>11</i> Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 6, 1894</i>	9. AGE (In years last birthday) <i>75</i> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Carroll Co Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>William H. Geiman</i>			
14. MOTHER'S MAIDEN NAME <i>Elizabeth Rachel Wilkin</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Miss Madeline Geiman Westminster Md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiovascular disease</i> DUE TO (c) <i>Obesity</i>				INTERVAL BETWEEN ONSET AND DEATH <i>July 3/59</i> <i>General</i> <i>yes</i> <i>General</i> <i>yes</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <i>Aug 8</i> , 1959, to <i>Sept 11</i> , 1959, that I last saw the deceased alive on <i>Sept 9</i> , 1959, and that death occurred at <i>7:00 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. Glenn Speicher</i> M.D.				ADDRESS (Street, city or town, State) <i>Westminster Md</i> DATE SIGNED <i>9/14/59</i>			
PHYSICIAN'S NAME (Type) <i>W. GLENN SPEICHER</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Sept. 14 59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Meadow Branch</i>		22d. LOCATION (City, town, or county) (State) <i>Rural Westminster, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Jr. Westminster, Md</i> ADDRESS				24a. REC'D BY REGISTRAR DATE <i>SEP 15 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10114

CERTIFICATE OF DEATH

10090

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Barnoll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Barnoll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>				c. LENGTH OF STAY IN 1b <u>30 yw</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CORAL- F - GRAHAM</u> First Middle Last				4. DATE OF DEATH <u>Sept 26 1959</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 15 - 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Hundertmark</u>				14. MOTHER'S MAIDEN NAME <u>Martha Boring</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-03-0822</u>			
17. INFORMANT <u>Barnoll Graham</u>				Address <u>Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous Metastasis to brain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the Ovary</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>175.0</u> <u>6 weeks</u> <u>2 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>59</u> , to <u>9-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-27</u> , 19 <u>59</u> , and that death occurred at <u>11:30 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M.C. Porterfield</u>				ADDRESS (Street, city or town, state) <u>Hampstead, Md</u>			
DATE SIGNED <u>9/28/59</u>							
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wm. Green</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin Clifton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>SEP 30 59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Wm. Green</u>	

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CERTIFICATE OF DEATH

10114

MINISTRY OF HEALTH - BANGKOK 10

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "CORPSE" and "DEATH" are visible.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10091

10113

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAIN ST NEW WINDSOR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN STREET</u>				d. STREET ADDRESS <u>MAIN STREET</u>			
3. NAME OF DECEASED (Type or print) First <u>ROSIE</u> Middle <u>HAINES</u> Last <u>HAINES</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 17-1881</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JESS FLICKINGER</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE KING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>IRA HAINES WESTMINSTER MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>9/1/58</u> , 19 <u>  </u> , to <u>9/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/27/59</u> , 19 <u>  </u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u>				ADDRESS (Street, city or town, state) <u>New Windsor Md</u>			
PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u>				DATE SIGNED <u>9/27/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 30-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN</u>		22d. LOCATION (City, town, or county) (State) <u>NEW WINDSOR MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W D Hargrave &amp; Sons New Windsor</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur P. Hearn</u>	



# CERTIFICATE OF DEATH

1911

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

REPORTED BY

SIGNATURE OF REPORTER

DATE OF REPORT

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10094

## CERTIFICATE OF DEATH

Reg. Dist. No.

10093

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN TB <u>30 year</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		d. STREET ADDRESS <u>96 E. Main St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>96 E. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LEWIN NELSON HITCHCOCK</u> First Middle Last		4. DATE OF DEATH <u>Sept. 14</u> 19 <u>59</u> Month Day Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 16/1907</u> 9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>	
11. BIRTHPLACE (State or foreign country) <u>Danburytown, Conn. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr. Nelson A. Hitchcock</u>		14. MOTHER'S MAIDEN NAME <u>Alice Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. L. N. Hitchcock</u>		Address <u>Westminster, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis (acute)</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>52</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1952</u> , to <u>Sept. 14, 1959</u> , that I last saw the deceased alive on <u>Sept. 13, 1959</u> , and that death occurred at <u>7:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. C. Bennett</u> M.D.		ADDRESS (Street, city or town, state) <u>Westminster, Md. 103 E. Main St.</u>	
DATE SIGNED <u>9-15-59</u>			
PHYSICIAN'S NAME (Type) <u>Wm. C. Bennett, M.D.</u>		<u>100 E. Main Westminster, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 6, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>R. Reform Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Danburytown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		ADDRESS <u>Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5 Film G248 9-17-59 et

CERTIFICATE OF DEATH

10094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster RD#3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Westminster RD#3</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>SARAH ELIZABETH HOSFELD</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1874</u>	9. AGE (In years last birthday) <u>84</u> yrs.	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eli Mull</u>				14. MOTHER'S MAIDEN NAME <u>Susannah Elizabeth Masenhimer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>E. Robert Hosfeld, Westminster, Md RD#3</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arterio-Sclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 1957</u> , 19____, to <u>Sept. 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>August 12</u> , 19 <u>59</u> , and that death occurred at <u>8:00 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. C. Porterfield</u>				ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>		DATE SIGNED <u>9/12/59</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>				ADDRESS <u>Hampstead, Md.</u>		DATE SIGNED <u>9/12/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 15, 1959</u>		<u>Leister's Cemetery</u>		<u>Rural Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers</u>				ADDRESS <u>Westminster, Md.</u>		24. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE	
				DATE <u>SEP 15 '59</u>			



10117

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3mos. 19days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Oliver</b> Last <b>Houck</b>		4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lloyd Houck</b>		14. MOTHER'S MAIDEN NAME <b>Mary Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-8408</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the prostate with metastasis to liver and lungs.</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 4, 1959</b> , to <b>September 23, 1959</b> , that I last saw the deceased alive on <b>September 23, 1959</b> , and that death occurred at <b>8:43 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>9/24/59</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-28-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Edmondson Ave. Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Ruth</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 28 '59</b>	
ADDRESS <b>1235 Hartford Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







10118

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>25yrs. 6mos. 13days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>				08X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>None</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Morris</b> Last <b>Jenkins</b>				4. DATE OF DEATH Month <b>September</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 13, 1890</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min.		IF UNDER 24 HRS. Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas C. Jenkins</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Compton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>			
17. INFORMANT <b>Springfield Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epileptic psychosis.</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>Sept. 7, 1959</b> , that I last saw the deceased alive on <b>September 7, 1959</b> , and that death occurred at <b>7:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield Hospital</b> DATE SIGNED <b>9/8/59</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b>				M.D. <b>Springfield Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9/11/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>St. Charles Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Sykesville, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard Funeral Home &amp; Plato, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 11 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hanna</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpse papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10119

## CERTIFICATE OF DEATH

10097

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b> c. LENGTH OF STAY IN b. <b>33 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sykesville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto</b> c. STREET ADDRESS <b>1823 N. Castle St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b> First Middle Last <b>Judd</b>		4. DATE OF DEATH <b>Sept. 5th 1959</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/23/1901</b> 9. AGE (In years last birthday) <b>58</b> IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>X</b>	
11. BIRTHPLACE (State or foreign country) <b>Md unknown ( Md )</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Judd</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Meyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>X</b>	
17. INFORMANT <b>Records Springfield State Hospital</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Marked Obesity Enlargement of heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Marked Obesity Enlargement of heart</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental deficiency without psychosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 53</b> to <b>Sept 4th 59</b> , that I last saw the deceased alive on <b>Sept. 4th 59</b> , and that death occurred at <b>2/45 am</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>Sept 5 1959</b>			
ACTUAL SIGNATURE <b>Myron Nizankowsky</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Myron Nizankowsky M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-8-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leo G. Cook</b>		24a. REC'D BY REGISTRAR <b>SEP 9 1959</b> DATE	
ADDRESS <b>1701 Baltimore Pk Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Harris</b>	

CERTIFICATE OF DEATH

10110

Name of Deceased		John Smith	
Sex		Male	
Age		2 / 10 / 1901	
Date of Birth		10/10/1901	
Place of Birth		Baltimore, Maryland	
Cause of Death		Heart Disease	
Date of Death		10/10/1901	
Place of Death		Baltimore, Maryland	
Signature of Physician		<i>[Signature]</i>	
Signature of Registrar		<i>[Signature]</i>	
Date of Registration		10/10/1901	
Place of Registration		Baltimore, Maryland	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10120  
CERTIFICATE OF DEATH

10098

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>9yrs.6mos.2days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>29 Holmshurst Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alden</b> Middle <b>Brewer</b> Last <b>Lawson</b>		4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 22, 1913</b>
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mr Clerical</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alden B. Lawson, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Mitchell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>491X</b> IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis associated with organic changes of nervous system, birth injury.</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of line 19.) <b>injury.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1955</b> to <b>September 23, 1959</b> , that I last saw the deceased alive on <b>September 23, 1959</b> , and that death occurred at <b>8:45AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>9/23/59</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/26/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mac Nabb + Son</b>		ADDRESS <b>28</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>	

1902-1903

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10121

Items 15 &amp; 22 Film G249 10/5/59 jwk

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>12yrs. 1mo. 3days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1033 St. Paul St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Eldridge Stuart Lee</b>		4. DATE OF DEATH Month Day Year <b>September 10, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 7, 1899</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry S. Lee</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Rolph</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute &amp; chronic myocardial infarction</b> Days & months DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary arteriosclerosis</b> Years (c) <b>Psychosis with chronic alcoholism with deterioration.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with chronic alcoholism with deterioration.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James T. Marsh</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>9/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Abingdon Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Gloucester Co., Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>DATE SEP 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hearn</i>			

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10122

CERTIFICATE OF DEATH

Reg. Dist. No.

10160

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4 yrs 11 mo 27 dys.</b> <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>		d. STREET ADDRESS <b>1629 Kingsway Road.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>C. Lippert</b> Last		4. DATE OF DEATH Month <b>9</b> - Day <b>26</b> - Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-82</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John G. Lippert</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Kellen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Hospital records</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction due to volvulus.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Broncho-pneumonia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-7-55</b> to <b>9-26-59</b> , that I last saw the deceased alive on <b>9-26-59</b> , and that death occurred at <b>7:01 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital.</b> DATE SIGNED <b>9-26-59</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		M.D. <b>Springfield State Hospital.</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/29/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lick...</b>		24a. REC'D BY REGISTRAR <b>SEP 28 59</b>	
ADDRESS <b>17</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur H. ...</b>	

515

3V01-4

MEDICAL CERTIFICATION

1

bp

CERTIFICATE OF DEATH

10752

10701

Decedent's Name: [Illegible]  
Date of Death: [Illegible]  
Place of Death: [Illegible]  
Age: [Illegible]

Sex: [Illegible]  
Race: [Illegible]  
Marital Status: [Illegible]  
Occupation: [Illegible]

Signature of Physician: [Illegible]  
Signature of Registrar: [Illegible]  
Date of Registration: [Illegible]

Signature of Medical Examiner: [Illegible]  
Signature of Coroner: [Illegible]  
Date of Examination: [Illegible]

Signature of Burial Director: [Illegible]  
Signature of Cemetery: [Illegible]  
Date of Burial: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10123

CERTIFICATE OF DEATH

Reg. Dist. No.

10101

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>10yrs. 7mos. 20days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>3400 Cedardale Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Rose</b> Middle <b>Lubbehusen</b> Last <b>Lubbehusen</b>			4. DATE OF DEATH Month <b>September</b> Day <b>24</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 18, 1881</b>	9. AGE (In years lost birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Joseph Lubbehusen</b>			14. MOTHER'S MAIDEN NAME <b>Blanche Knott</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		INFORMANT Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic rheumatic heart disease</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis, paranoid type.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>March 7, 1955</b> to <b>September 24, 1959</b> , that I last saw the deceased alive on <b>September 23, 1959</b> , and that death occurred at <b>6:30AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>9/24/59</b> ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. <b>Springfield State Hospital</b> PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Sickner &amp; Sons - Balto</b> <b>17 Md</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Cirhan &amp; Kines</b>	

10785

STATE OF TEXAS

10785

County of ...

State of Texas

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10124

CERTIFICATE OF DEATH

10102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>14yrs. 6mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Joseph</b> Last <b>McNamara</b>		4. DATE OF DEATH Month <b>September</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 6, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Letter carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John McNamara</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Quirk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Arteriosclerotic Heart disease</b> IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with cerebral arteriosclerosis in a psychoneurotic setting.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>September 14, 1959</b> , that I last saw the deceased alive on <b>September 14, 1959</b> , and that death occurred at <b>6:00P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield Hospital Records 9/15/59</b> ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. <b>Agustin del Campo, M.D.</b> PHYSICIAN'S NAME (Type) <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-18-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST MARY'S GLOVANS</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H Evans</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 18 '59</b>	
ADDRESS <b>118 W. Mt. Royal Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>	

# CERTIFICATE OF DEATH

1912

Name of Deceased: [illegible] Sex: [illegible] Age: [illegible]

Place of Birth: [illegible] Date of Birth: [illegible]

Place of Death: [illegible] Date of Death: [illegible]

Cause of Death: [illegible]

Signature of Physician: [illegible]

Signature of Registrar: [illegible]

Signature of Coroner: [illegible]

Signature of Burial Officer: [illegible]

Signature of Medical Officer: [illegible]

Signature of Health Officer: [illegible]

Remarks: [illegible]

Witness: [illegible]

Signature of Registrar: [illegible]

Signature of Coroner: [illegible]

Signature of Burial Officer: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10125

## CERTIFICATE OF DEATH

Reg. Dist. No.

10103

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>30yrs. 3mos. 16days</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>7 W. West Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Miller</b> Last <b>Miller</b>		4. DATE OF DEATH Month <b>September</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 23, 1893</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Miller</b>		14. MOTHER'S MAIDEN NAME <b>Mary Dailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of unknown origin with metastasis</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>-</b> DUE TO (c) <b>-</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sociopathic personality disturbance, antisocial reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 11, 1958</b> to <b>September 3, 1959</b> , that I last saw the deceased alive on <b>September 3, 1959</b> , and that death occurred at <b>8:10P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Francesco Magro M.D.</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>9/4/59</b>	
PHYSICIAN'S NAME (Type) <b>Francesco Magro, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burn</b>		22b. DATE THEREOF <b>9/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Burnside Jr.</b>		ADDRESS <b>955 Southridge Rd.</b>	
24a. RECEIVED BY REGISTRAR <b>SEP 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krawa</b>	

10113

CERTIFICATE OF DEATH

10113

Name of Deceased		Date of Death	
John Doe		January 1, 1913	
Age		Sex	
35		Male	
Marital Status		Cause of Death	
Single		Heart Disease	
Place of Birth		Place of Death	
New York		New York	
Occupation		Signature of Physician	
Teacher		[Signature]	
Date of Burial		Burial Place	
January 5, 1913		Cemetery	
Name of Undertaker		Remarks	
John Doe		[Remarks]	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1009 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10104

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CARROLL COUNTY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER, MD.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>19 RIDGE ROAD -</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNIONTOWN RD #1</u> d. STREET ADDRESS <u>TREVANION ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>VIRGINIA</u> Middle <u>IRENE</u> Last <u>MITTEN</u> <b>4. DATE OF DEATH</b> Month <u>SEPT.</u> Day <u>5</u> Year <u>1959</u>				<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>JULY 12, 1921</u> <b>9. AGE</b> (In years last birthday) <u>38</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>WESTMINSTER SHOE FACTORY STITCHER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>WESTMINSTER, MD.</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>USA.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>				<b>13. FATHER'S NAME</b> <u>CHARLES UPTON MITTEN</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>EMMA IRENE MASENHIMER</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> <b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service) <u>214-14-6863</u> <b>17. INFORMANT</b> <u>DR. WELLIVER</u> Address <u>19 RIDGE RD. WESTMINSTER</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C of Pulmonary</u> DUE TO <u>Bilateral Pulmonary Tuberculosis w/ Cavitation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> 19 <u>  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> (County) (State) <u>  </u> <u>  </u> <u>  </u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input "="" checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> </b>							
<b>ACTUAL SIGNATURE</b> <u>James I Marsh</u> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>JAMES I MARSH</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>9/5/59</u> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>22b. DATE THEREOF</b> <u>9/9/59</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>SILVER RUN CEMETERY</u> <b>22d. LOCATION (City, town, or county)</b> (State) <u>SILVER RUN MD.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James G. Saffell</u> <b>ADDRESS</b> <u>Westminster, Md.</u> <b>24a. REC'D BY REGISTRAR</b> <u>  </u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Carling E. Kneass</u>				<b>DATE</b> <u>SEP 8 '59</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





10126

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2mos.18days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>516 W. Fayette St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Herman</b> Middle <b>Fred</b> Last <b>Nerking</b>				4. DATE OF DEATH Month <b>September</b> Day <b>24</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 17, 1891</b>	
9. AGE (In years lost birthday) yrs. <b>68</b>		10. IF UNDER 1 YEAR Months <b>68</b> Days <b>0</b> Hours <b>0</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metal worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-14-2005</b>			
17. INFORMANT <b>Springfield Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Cancer of the rectum</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Months</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 6, 1959</b> to <b>September 24, 1959</b> that I last saw the deceased alive on <b>September 23, 1959</b> and that death occurred at <b>7:00AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>9/24/59</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.				PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9-28-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Robert Lee Memorial Park</b>				22d. LOCATION (City, town, or county) (State) <b>Robert Lee Memorial Park, Sykesville, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Wright</b>				24a. REC'D BY REGISTRAR <b>OCT 1 '59</b>			
ADDRESS <b>Sykesville, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur H. Wright</b>			

1015

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10/10

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

10158

MASSACHUSETTS DEPARTMENT OF HEALTH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to the quality of the scan.

10127

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr. 4mos. 15days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1517 S. Clinton St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Francis</b> Last <b>Nevins</b>		4. DATE OF DEATH Month <b>September</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1906</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk.</b>	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin Nevins</b>		14. MOTHER'S MAIDEN NAME <b>Letitia Judge</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Far advanced pulmonary tuberculosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 9, 1958</b> , to <b>September 24, 1959</b> , that I last saw the deceased alive on <b>September 24, 1959</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustini del Campo</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		DATE SIGNED <b>9/25/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-29-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's</b>		22d. LOCATION (City, town, or county) (State) <b>Windsor, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Haight, Sykesville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur A. Haight</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10187

CERTIFICATE OF DEATH

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 1 Film G249 10/5/59 iwk

10107

10128

Reg. Dist. No. ....

## CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Carroll</b>		MARYLAND		STATE <b>Penna.</b>		COUNTY <b>Northumberland</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>rural Finksburg</b>		LENGTH OF STAY (in this place) <b>1 Month</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>rural Sunbury</b>		<b>75x-3</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓ <b>Brown Road - Daughter's home - Mrs. F.N. Herman</b>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Agnes Verdilla Newman</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Sept. 29 1959</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>April 23, 1880</b>	<b>9. AGE last birthday</b> <b>75</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Snyder Co. Penna.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>	
<b>13. FATHER'S NAME</b> <b>Oliver Snyder</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Burkey</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> - - - - -		<b>17. INFORMANT &amp; ADDRESS</b> <b>Fred Herman Finksburg, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>162-1 IMMEDIATE CAUSE (A)</b> <b>BRONCHOGENIC CARCINOMA</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 wks.</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<b>DUE TO (C)</b> <b>ARTERIOSCLEROTIC C.V. DISEASE</b> <b>YEARS</b>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>SEPT. 15, 1959</b> , to <b>SEPT. 29, 1959</b> , that I last saw the deceased alive on <b>SEPT. 28, 1959</b> , and that death occurred at <b>10:15 P.M.</b> from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>Martin E. Stoppel</b>		<b>DATE THEREOF</b> <b>10-3-59</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Halls Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>McKee's Half Falls, Pa.</b>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>10-3-59</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Halls Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>McKee's Half Falls, Pa.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>OCT 1 '59</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Arthur E. Thomas</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John R. Byers</b>		<b>ADDRESS</b> <b>Westminster, Md.</b>	

# CERTIFICATE OF DEATH

10128

Res. Dist. No.

NAME OF DECEASED Carlota		SEX Female		AGE 1 month	
PLACE OF BIRTH Brown Road		RACE White		DATE OF BIRTH April 23, 1950	
PLACE OF DEATH Brown Road		RACE White		DATE OF DEATH April 23, 1950	
NAME OF DECEASED Oliver Sade		SEX Male		AGE 1 month	
PLACE OF BIRTH Brown Road		RACE White		DATE OF BIRTH April 23, 1950	
PLACE OF DEATH Brown Road		RACE White		DATE OF DEATH April 23, 1950	
NAME OF DECEASED Mary Bailey		SEX Female		AGE 1 month	
PLACE OF BIRTH Brown Road		RACE White		DATE OF BIRTH April 23, 1950	
PLACE OF DEATH Brown Road		RACE White		DATE OF DEATH April 23, 1950	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, BALTIMORE, MD. IT IS NOT VALID FOR ANY OTHER PURPOSES.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10129

## CERTIFICATE OF DEATH

10108

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>		c. LENGTH OF STAY IN 1b <b>12 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Westminster, Md. R. D. 1 (Silver Run)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Louise</b> Last <b>Null</b>		4. DATE OF DEATH Month <b>September</b> , Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/7/1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Her own home (Ret.)</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Hosefeld</b>		14. MOTHER'S MAIDEN NAME <b>Louise Rinehart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>W. Oscar Null, Westminster, Md. R.D.1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC MYOCARDITIS &amp; MYOCARDIAL DEGENERATION</b> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRONCHIAL ASTHMA</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b> <b>30 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 27</b> , 19 <b>59</b> , to <b>Sept. 14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 12</b> , 19 <b>59</b> , and that death occurred at <b>8:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. L. Potter</b>		ADDRESS (Street, city or town, state) <b>12 W. KING ST. LITTLESTOWN, PA</b>	
PHYSICIAN'S NAME (Type) <b>L. L. POTTER M.D.</b>		DATE SIGNED <b>9-14-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/17/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bachmans Valley Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bachmans Valley, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		ADDRESS <b>Littlestown, Pa.</b>	
24a. REC'D BY REGISTRAR <b>SEP 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Huns</b>	



10130

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>4 mos.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>Wooden</b> Last <b>Parent</b>				4. DATE OF DEATH Month <b>September</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 3, 1908</b>		9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Philip Wooden</b>				14. MOTHER'S MAIDEN NAME <b>Valentine Odett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>		INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Reactive Depression.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 26, 1959</b> to <b>September 25, 1959</b> , that I last saw the deceased alive on <b>September 25, 1959</b> , and that death occurred at <b>8:50 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank Magro</b>		M.D. <b>Springfield State Hospital</b>		DATE SIGNED <b>9/25/59</b>			
PHYSICIAN'S NAME (Type) <b>Frank Magro, M.D.</b>		<b>Sykesville, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-28-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>				ADDRESS <b>5305 Harford Rd</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 29 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur A. Thomas</b>	

DEPT. OF HEALTH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10110

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5yrs.5mos.16days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hampstead</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charlotte</b> Middle <b>Virginia</b> Last <b>Wilhelm Rinaman</b>				4. DATE OF DEATH Month <b>September</b> Day <b>17</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 9, 1870</b>		9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>88</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Wilhelm</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Basson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage into left pleura</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dissecting Aneurysm of the arch of the aorta</b> years (c) <b>Arteriosclerosis</b> years							INTERVAL BETWEEN ONSET AND DEATH hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with senile brain disease with psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>9/16/ 1959</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James T. Marsh</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		9/17/59	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hampstead</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edw E. Tipton - Hampstead Md</b>				ADDRESS <b>Hampstead Md</b>		24a. REC'D BY REGISTRAR <b>SEP 22 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kinn</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

BALTIMORE DEPARTMENT OF HEALTH—BALTIMORE, 18														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
Reg. Dist. No.														
1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b> c. LENGTH OF STAY IN 1b <b>Taneytown</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R. D. #1 M</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b> d. STREET ADDRESS <b>R. D. #1 M</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>SANTO</b> Middle <b>ROCCELLA</b> Last <b>ROCCELLA</b>					4. DATE OF DEATH Month <b>September</b> Day <b>7</b> Year <b>1959</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/23/1893</b>		9. AGE (In years last birthday) <b>65</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Sicily</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b> IF UNDER 24 HRS. Hours <b>14</b> Min.						
13. FATHER'S NAME <b>Paola Roccella</b>					14. MOTHER'S MAIDEN NAME <b>Santa Calderaro</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW 1</b>					16. SOCIAL SECURITY NO. <b>220-38-1425</b>					17. INFORMANT <b>Niece</b> Address <b>Mary Borzi-9402 Kingsley Ave. Beth. Md</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> <b>981X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot in head</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour <b>Between 9/28</b> a.m. <b>9/6/59</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>Taneytown Carroll Md</b>							
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .										DATE SIGNED <b>9/8/59</b>				
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>			22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>					ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>					



10133

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>				c. LENGTH OF STAY IN 1b <b>4 y 3 m 15 d</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>17 S. Robinson Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Schech</b> Last <b>Schech</b>				4. DATE OF DEATH Month <b>September</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1875</b>		9. AGE (In years last birthday) <b>84 yrs.</b>	IF UNDER 1 YEAR: Months <b>84</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Conrad Schroll</b>				14. MOTHER'S MAIDEN NAME <b>Mary Schroll KRIPP</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Springfield State Hospital Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Bronchopneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Years</b> <b>Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with senile brain disease with psychotic reaction.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 1, 1957</b> , to <b>September 1, 1959</b> , that I last saw the deceased alive on <b>September 1, 1959</b> , and that death occurred at <b>1:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>9-1-59</b>							
ACTUAL SIGNATURE <b>Rita S. Glahn</b>				M.D. <b>Springfield State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Rita S. Glahn, M. D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD., MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Geiler</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Critter &amp; Thoma</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10112

CERTIFICATE OF DEATH

10133

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH 1874	
5. PLACE OF BIRTH Maryland		6. OCCUPATION Farmer	
7. MARITAL STATUS Married		8. CAUSE OF DEATH Heart Disease	
9. DATE OF DEATH 1940		10. PLACE OF DEATH Home	
11. SIGNATURE OF DECEASED James H. Harris		12. SIGNATURE OF WITNESS John D. Smith	
13. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		14. SIGNATURE OF CLERK John D. Smith	
15. SIGNATURE OF REGISTRAR John D. Smith		16. SIGNATURE OF JURY John D. Smith	
17. SIGNATURE OF JURY John D. Smith		18. SIGNATURE OF JURY John D. Smith	
19. SIGNATURE OF JURY John D. Smith		20. SIGNATURE OF JURY John D. Smith	
21. SIGNATURE OF JURY John D. Smith		22. SIGNATURE OF JURY John D. Smith	
23. SIGNATURE OF JURY John D. Smith		24. SIGNATURE OF JURY John D. Smith	
25. SIGNATURE OF JURY John D. Smith		26. SIGNATURE OF JURY John D. Smith	
27. SIGNATURE OF JURY John D. Smith		28. SIGNATURE OF JURY John D. Smith	
29. SIGNATURE OF JURY John D. Smith		30. SIGNATURE OF JURY John D. Smith	
31. SIGNATURE OF JURY John D. Smith		32. SIGNATURE OF JURY John D. Smith	
33. SIGNATURE OF JURY John D. Smith		34. SIGNATURE OF JURY John D. Smith	
35. SIGNATURE OF JURY John D. Smith		36. SIGNATURE OF JURY John D. Smith	
37. SIGNATURE OF JURY John D. Smith		38. SIGNATURE OF JURY John D. Smith	
39. SIGNATURE OF JURY John D. Smith		40. SIGNATURE OF JURY John D. Smith	
41. SIGNATURE OF JURY John D. Smith		42. SIGNATURE OF JURY John D. Smith	
43. SIGNATURE OF JURY John D. Smith		44. SIGNATURE OF JURY John D. Smith	
45. SIGNATURE OF JURY John D. Smith		46. SIGNATURE OF JURY John D. Smith	
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63. SIGNATURE OF JURY John D. Smith		64. SIGNATURE OF JURY John D. Smith	
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81. SIGNATURE OF JURY John D. Smith		82. SIGNATURE OF JURY John D. Smith	
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99. SIGNATURE OF JURY John D. Smith		100. SIGNATURE OF JURY John D. Smith	

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RECEIVED BY THE CLERK OF THE COURT OF COMMON PLEAS, BALTIMORE, MARYLAND, ON 10-1-40

10096

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster,</b>		c. LENGTH OF STAY IN 1b <b>8 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jordan Nursing Home, 127 E. Green St.</b>				/d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Ann</b> Last <b>Sell</b>				4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 13, 1865</b>		9. AGE (In years last birthday) <b>94 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Sell</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hesson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		INFORMANT Address <b>Mr. Howard Maus, R #7, Westminster, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial degeneration</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>1 mo. 2 yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>50</b> , to <b>Sept 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 20</b> , 19 <b>59</b> , and that death occurred at <b>3 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. Reese Wilkens</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>15 Kempers? 12/5/59</b>			
PHYSICIAN'S NAME (Type) <b>E. REESE WILKENS</b>				<b>Westminster Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baust Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Tyrone, Carroll, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b> <b>G.O. Fuss &amp; Son</b>				ADDRESS <b>Taneytown, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 25 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Kraus</b>			

10095

CERTIFICATE OF DEATH

Carroll, Maryland

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

10134  
10114  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Manchester</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Manchester</b>			
c. LENGTH OF STAY IN TB				d. STREET ADDRESS <b>12 New Street</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>12 New Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LEROI</b> <b>ARNOLD</b> <b>SHORB</b>				4. DATE OF DEATH <b>September 18, 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/25/42</b>	
9. AGE (in years last birthday) <b>16 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Shorb</b>				14. MOTHER'S MAIDEN NAME <b>Elsie Markle</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>18-40-2303</b>				16. SOCIAL SECURITY NO. <b>Charles Shorb</b>			
17. INFORMANT <b>Charles Shorb</b>				Address <b>Manchester, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>330x Massive subarachnoid hemorrhage</b> DUE TO (b) <b>rupture of congenital aneurysm with anterior cerebral artery.</b> DUE TO (c) <b>artery.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr., M.D.</b>				DATE SIGNED <b>9/19/59</b>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9/21/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Manchester</b>				22d. LOCATION (City, town, or country) (State) <b>Manchester, Md.</b>			
23. FUNERAL DIRECTOR <b>Edward C. Tipton</b>				24a. REC'D BY REGISTRAR <b>SEP 22 59</b> 24b. REGISTRAR'S SIGNATURE <b>Edward C. Tipton</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10135  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No.

10115

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline County</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		d. STREET ADDRESS <b>River Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Simms</b> Last <b>Simms</b>		4. DATE OF DEATH Month <b>September</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 8, 1883</b>
9. AGE (In years lost birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>7</b> Hours <b>15</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Caroline Poultry</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Simms</b>		14. MOTHER'S MAIDEN NAME <b>Millie Jinkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
INFORMANT <b>Thomas Simms</b>		Address <b>Federalsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Far advanced pulmonary tbc. with cavitation</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 29</b> , 19 <b>59</b> , to <b>September 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>September 7</b> , 19 <b>59</b> , and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>9-7-59</b> ACTUAL SIGNATURE <b>Edgars M. Maculans</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt.</b> <b>Henryton State Hospital, Henryton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 10, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraw</b>			

10118

CERTIFICATE OF DEATH

10132

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 250 10-14-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

10116

10136

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3701-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Unknown - came from Balto. City Hospitals, 100 Marbit Pl.</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Grover</b> Last <b>Sims</b>		4. DATE OF DEATH Month <b>September</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>December 5, 1894</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seaman</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Seabron Sims</b>		14. MOTHER'S MAIDEN NAME <b>Abbie Henson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-05-5105</b>	
17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Recurrent carcinoma of the lung</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type (with incipient CBS with cerebral arteriosclerosis)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 31, 1958</b> , to <b>September 29, 1959</b> , that I last saw the deceased alive on <b>September 28, 1959</b> , and that death occurred at <b>7: A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		DATE SIGNED <b>9/29/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-3-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Plain</b>		22d. LOCATION (City, town, or county) (State) <b>Pensacola, S.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Haight</b>		ADDRESS <b>Sykesville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>OCT 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Henson</b>	





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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10117

10137

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>23 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. STREET ADDRESS <b>6500 Lehnert Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Myrta</b> Middle <b>Isabel</b> Last <b>Snider</b>		4. DATE OF DEATH Month <b>September</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1878</b>
9. AGE (In years last birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>1</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Months <b>8</b> Days <b>1</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Snider</b>		14. MOTHER'S MAIDEN NAME <b>Sara Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic nephrosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with arteriosclerotic heart disease.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 11, 1959</b> to <b>September 7, 1959</b> , that I last saw the deceased alive on <b>September 6, 1959</b> , and that death occurred at <b>6:20A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>9/7/59</b> ACTUAL SIGNATURE <b>Agustin del Campo</b> PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8-9-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balt.</b> <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Forley Funeral Home-Citronville</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 9 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knaus</b>	

# CERTIFICATE OF DEATH

10432

State of Maryland, County of Baltimore, City of Baltimore, District of Columbia, and the District of Columbia.

I, the undersigned, being a duly qualified Medical Officer of Health for the City and District of Columbia, do hereby certify that

On the 13th day of September, 1917, at the City of Baltimore, District of Columbia, died

John J. Smith, of the City of Baltimore, District of Columbia, who was born on the 13th day of September, 1877, at the City of Baltimore, District of Columbia.

He was a native-born American citizen, and was at the time of his death a resident of the City of Baltimore, District of Columbia.

He was afflicted with a long-standing disease of the heart, which finally resulted in a fatal attack of coronary thrombosis.

He was taken ill on the 10th day of September, 1917, at the City of Baltimore, District of Columbia, and died on the 13th day of September, 1917, at the City of Baltimore, District of Columbia.

He was buried on the 15th day of September, 1917, at the City of Baltimore, District of Columbia, in the City of Baltimore, District of Columbia.

Witness my hand and the seal of the City and District of Columbia, this 14th day of September, 1917.

John J. Smith, M.D., Medical Officer of Health for the City and District of Columbia.

Attest: My hand and the seal of the City and District of Columbia, this 14th day of September, 1917.

John J. Smith, M.D., Medical Officer of Health for the City and District of Columbia.

Attest: My hand and the seal of the City and District of Columbia, this 14th day of September, 1917.

John J. Smith, M.D., Medical Officer of Health for the City and District of Columbia.

Attest: My hand and the seal of the City and District of Columbia, this 14th day of September, 1917.

John J. Smith, M.D., Medical Officer of Health for the City and District of Columbia.

Attest: My hand and the seal of the City and District of Columbia, this 14th day of September, 1917.

John J. Smith, M.D., Medical Officer of Health for the City and District of Columbia.

Attest: My hand and the seal of the City and District of Columbia, this 14th day of September, 1917.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4. See: Item 21, et (By phone, F.D.)

## CERTIFICATE OF DEATH

10118

Reg. Dist. No.

10138

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Mt. Airy</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Mt. Airy</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BERT</b> Middle <b>O.</b> Last <b>SWARTZ</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-7-1892</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ordinance Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Army</b>		11. BIRTHPLACE (State or foreign country) <b>Ill.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Jesse Swartz</b>				14. MOTHER'S MAIDEN NAME <b>Clara Brodbeck</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-32-8904</b>		17. INFORMANT Address <b>Mrs. Lillian Swartz, same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malignant tumor of bladder</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/29/58</b> , 19____, to <b>9/18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9/18/</b> , 19 <b>59</b> , and that death occurred at <b>1:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Main Street</b> DATE SIGNED _____							
ACTUAL SIGNATURE <b>Gilcin F. Meadors, M.D.</b>				M.D. <b>Main Street</b>			
PHYSICIAN'S NAME (Type) <b>Gilcin F. Meadors, M.D.</b>				<b>Damascus, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-21-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>				ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 22 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur B. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10139  
CERTIFICATE OF DEATH

10119

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN lb <b>8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 22</b> d. STREET ADDRESS <b>2939 Liberty Parkway</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Wilbur Lenonard Vogel Jr.</b>		4. DATE OF DEATH Month Day Year <b>9 6 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/17/18</b>
9. AGE (In years last birthday) <b>41</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>3 20</b>	11. IF UNDER 24 HRS. Hours Min. <b>3 20</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL MFCR.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wilbur Lenonard Vogel, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Esther Rymond</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>168-18-6802</b>	
17. INFORMANT <b>Wife- Irene Vogel</b>		18. ADDRESS <b>Baltimore 22, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas with metastasis in liver and lungs</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>157x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-29-</b> , 19 <b>59</b> , to <b>9-6-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9-6-</b> , 19 <b>59</b> , and that death occurred at <b>5 A.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		DATE SIGNED <b>9-6-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/9/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LAUREL HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>INDIANLAND PENN</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Bente Bradley, Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film C249 8/25/59 4-1

10140

## CERTIFICATE OF DEATH

10120

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Uniontown</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Effie</b> Middle <b>Viola</b> Last <b>Wagner</b>				4. DATE OF DEATH Month <b>September</b> Day <b>12</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1881</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Wagner</b>				14. MOTHER'S MAIDEN NAME <b>Mary Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Mr. William Segafosse, Uniontown, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Intestine</b> <b>153.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs -</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan. 1, 1959</b> to <b>Sept 12, 1959</b> that I last saw the deceased alive on <b>Sept 14, 1959</b> and that death occurred at <b>M</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. N. Legg</b>				ADDRESS (Street, city or town, state) <b>Union Bridge Md</b>			
PHYSICIAN'S NAME (Type) <b>T. N. Legg</b>				DATE SIGNED <b>9-14-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Haugh's Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>New Midway, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son</b>				ADDRESS <b>Taneytown, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 16 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

STATEMENT OF CASE

10180

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County: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Date of Onset: \_\_\_\_\_  
Duration: \_\_\_\_\_

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Occupation: \_\_\_\_\_  
Education: \_\_\_\_\_  
Marital Status: \_\_\_\_\_  
Previous Illnesses: \_\_\_\_\_

Family History: \_\_\_\_\_  
Social History: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Current Medications: \_\_\_\_\_

Physical Examination: \_\_\_\_\_  
Vital Signs: \_\_\_\_\_  
Laboratory Tests: \_\_\_\_\_  
Immunization Status: \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
Treatment: \_\_\_\_\_  
Prognosis: \_\_\_\_\_  
Follow-up: \_\_\_\_\_

Physician: \_\_\_\_\_  
Nurse: \_\_\_\_\_  
Hospital: \_\_\_\_\_  
Date: \_\_\_\_\_

10097

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>265 E. Main St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH <b>Sept. 13th 1959</b>				5. SEX <b>M</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>11/22/ 1919</b> 9. AGE (In years lost birthday) <b>39</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>owner operator of service station</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles W. Wagner</b>				14. MOTHER'S MAIDEN NAME <b>Margaret M. Grabbs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>W.W.II</b>				16. SOCIAL SECURITY NO. <b>215-18-248</b>			
17. INFORMANT <b>Annabel G. Wagner</b> Address <b>265 E. Main St. (wife)</b> <b>Westminster, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 10, 1951</b> , to <b>Sept 13, 1959</b> , that I last saw the deceased alive on <b>Sept 12, 1959</b> , and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Julius Chepko</b> M.D. <b>Westminster Md</b>				DATE SIGNED <b>9/14/59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Chepko.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 16th 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Finksburg, Carroll Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James A. Saffell</b> ADDRESS <b>254 E. Main St. Westminster</b>				24a. REC'D BY REGISTRAR <b>SEP 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles B. Knack</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2025 RELEASE UNDER E.O. 14176

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10141

CERTIFICATE OF DEATH

Reg. Dist. No.

10122

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>18yrs.7mos.11days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manchester</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>V.</b> Last <b>Warner</b>		4. DATE OF DEATH Month <b>September</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George L. Warner</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
14. MOTHER'S MAIDEN NAME <b>Maudy Heindel</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>			
16. SOCIAL SECURITY NO. <b>-</b>		INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of both lungs</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Carcinoma of left breast which was removed by operation.</b> DUE TO (c) <b>Psychosis with organic changes of the nervous system.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with organic changes of the nervous system.</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 11, 1958</b> to <b>September 3, 1959</b> , that I last saw the deceased alive on <b>September 3, 1959</b> , and that death occurred at <b>10:10 P.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Francesco Magro M.D.</b>		M.D. <b>Springfield State Hospital</b>		DATE SIGNED <b>9/4/59</b>	
PHYSICIAN'S NAME (Type) <b>Francesco Magro, M.D.</b>		ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reformed</b>	
22d. LOCATION (City, town, or county) (State) <b>Manchester Carroll Co. Md</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Allen Rock, Pa.</b> ADDRESS <b>Allen Rock, Pa.</b>			
24a. REC'D BY REGISTRAR <b>SEP 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

10112

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10123

10142

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2yr.7mo.13days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>				b. COUNTY <b>Montgomery</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>3003 Kingswell Drive</b>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Encelle Wayman</b>				4. DATE OF DEATH Month Day Year <b>September 2 19 59</b>															
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 10, 1879</b>		9. AGE (In years last birthday) yrs. <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MACHINERY MFG.</b>				11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas E. Wayman</b>				14. MOTHER'S MAIDEN NAME <b>Alice Brock</b>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>236-16-6778</b>				INFORMANT <b>Springfield Hospital Records</b>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute prostatic abscess</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Bilateral suppurative nephritis</b> DUE TO (c) <b>CBS assoc. with dist. of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.</b>												INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with dist. of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.</b>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from <b>January 19, 1957</b> , to <b>September 2, 1959</b> , that I last saw the deceased alive on <b>September 2, 19 59</b> , and that death occurred at <b>9:45P</b> M, from the causes and on the date stated above.																			
ACTUAL SIGNATURE <b>Agustin del Campo</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>				DATE SIGNED <b>9/3/59</b>											
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				SYKESVILLE, MARYLAND															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>				22b. DATE THEREOF <b>9/5/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Fairmont, West Virginia</b>									
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</b>						24a. REC'D BY REGISTRAR <b>Raymond A. Luska</b>		24b. REGISTRAR'S SIGNATURE <b>SEP 8 '59</b>											

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# CERTIFICATE OF DEATH

10143

Montgomery

San Juan

County

Elmer Spring

San Juan, N.M.

Residence

3003 Broadway Drive

San Juan State Hospital

Age

Sex

Occupation

Married

Education

Religion

Dec. 10, 1979

Time

Place

San Juan

Signature

Local Health Officer

Thomas H. Wagoner

San Juan State Hospital

100-1000

File

Date

Time of death

Age

Illness

Signature

Dec. 10, 1979, at San Juan, N.M., of heart failure, caused by coronary artery disease.

December 10, 1979

Signature

Signature

San Juan State Hospital

Signature

San Juan, N.M.

Signature

San Juan, N.M.

Signature

Signature

10143

## CERTIFICATE OF DEATH

10124

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>		c. LENGTH OF STAY IN 1b <b>2 y 3 m 1 d</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>5 N. East Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Pauline</b> Middle <b>Matilda</b> Last <b>Wiegand</b>		4. DATE OF DEATH Month <b>September</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>October 5, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Karl Gerlach</b>		14. MOTHER'S MAIDEN NAME <b>Maria Lemmert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-25-7901</b>	
17. INFORMANT <b>Springfield State Hospital Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>422.1</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Disease</b> (c) <b>Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with senile brain disease, with psychotic reaction.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 23, 1959</b> , to <b>September 4, 1959</b> , that I last saw the deceased alive on <b>September 4, 1959</b> , and that death occurred at <b>10:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Konstantin Weber</b> M.D.		ADDRESS (Street, city or town, state) <b>Oak Street</b> DATE SIGNED <b>9/4/59</b>	
PHYSICIAN'S NAME (Type) <b>Konstantin Weber, M. D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-5-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Freedom</b>	22d. LOCATION (City, town, or county) (State) <b>Freedom, Carroll Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Haight</b>		ADDRESS <b>Sykesville, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haight</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10144

## CERTIFICATE OF DEATH

Reg. Dist. No.

10125

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Conv. Home</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD - J - WISE</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4 - 1867</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George L Wise</u>		14. MOTHER'S MAIDEN NAME <u>Eva M Kolin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>420-03-6311</u>	
17. INFORMANT <u>Mrs Clarence Miller - Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 8</u> , 19 <u>59</u> , to <u>Sept 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 8</u> , 19 <u>59</u> , and that death occurred at <u>5:45</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Maryland</u> DATE SIGNED <u>9/8/59</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush</u>		<u>170 HAMPSTEAD MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Snydersburg</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Lipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>SEP 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

1014

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1920</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1945</i>		9. NAME OF SPOUSE <i>Jane Doe</i>		10. PLACE OF MARRIAGE <i>Baltimore, Md.</i>		11. CAUSE OF DEATH <i>Heart Disease</i>		12. PLACE OF DEATH <i>Home</i>	
13. DATE OF DEATH <i>Dec 10 1965</i>		14. TIME OF DEATH <i>10:00 AM</i>		15. PLACE OF DEATH <i>Home</i>		16. NAME OF PHYSICIAN <i>Dr. J. Smith</i>		17. NAME OF HOSPITAL <i>None</i>		18. NAME OF NURSE <i>None</i>	
19. NAME OF FUNERAL HOME <i>None</i>		20. NAME OF BURIAL PLACE <i>None</i>		21. NAME OF CEMETERY <i>None</i>		22. NAME OF INTERMENT <i>None</i>		23. NAME OF CREMATOR <i>None</i>		24. NAME OF CREMATION <i>None</i>	
25. NAME OF CORONER <i>None</i>		26. NAME OF JURY <i>None</i>		27. NAME OF JUDGE <i>None</i>		28. NAME OF CLERK <i>None</i>		29. NAME OF RECORDS <i>None</i>		30. NAME OF ARCHIVE <i>None</i>	

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THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE COUNTY CLERK, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND STATISTICAL PURPOSES.